Registered Nurse

Essential Task Rating Results

1	Evaluate patient/client condition (e.g., bio/psycho/social status, diet, physical activity, vital signs) on an on-going basis to promote and/or improve their overall health utilizing professional training and various resources in accordance with the guidelines established by regulatory agencies and others.
2	Administer medications and/or treatments to patients/clients to provide continuity, timeliness, and appropriateness of health care using accepted standards of care in accordance with the guidelines established by regulatory agencies and others.
3	Advocate for the appropriate administration of medications and/or treatments to patients/clients to provide continuity, timeliness, and appropriateness of health care using accepted standards of care in accordance with the guidelines established by regulatory agencies and others.
4	Monitor and/or ensure therapeutic intervention to assist patients/clients in regaining and maximizing their physical abilities in accordance with established standards of practice.
5	Monitor and/or ensure patients/clients engage in range of motion to the best of their ability to maintain or improve their condition in accordance with established standards of practice.
6	Provide a therapeutic nursing environment using communication techniques and interventions from the patient's/client's behavior plan to encourage them to increase pro-social behaviors and to decrease maladaptive behaviors.
7	Evaluate nursing care and treatment provided to patients/clients in conjunction with the interdisciplinary team, to ensure timeliness and appropriateness of health care, adhering to various laws, rules, regulations, policies, procedures, etc.
8	Advocate for patients/clients on an ongoing basis to ensure appropriate treatment is provided utilizing professional skills and training.
9	Provide necessary medical treatment in the event of a change in condition or an emergency (e.g., change in consciousness, heart attack, stroke, etc.) to help ensure the safety of the patient/client.
10	Evaluate circumstances in the event of a change in condition or an emergency to ensure proper course of action is taken utilizing professional training and various resources in accordance with the guidelines established by regulatory agencies and others.
11	Participate in treatment planning conferences for patients/clients on admission and at established intervals per facility protocol or as needed to assess significant changes in patient/client condition.

12	Monitor and/or ensure proper body positioning and body alignment of bedbound patients/clients to ensure optimal level of comfort and circulation for them.
13	Assess and monitor patients/clients to ensure adequate nutrition and consumption of fluids based upon the physician's diet order.
14	Collaborate with the interdisciplinary team and/or the registered dietician in developing care plans for patients/clients with identified nutritional and/or fluid issues.
15	Evaluate and modify patient/client treatment plans to correspond with evolving patient/client care needs to maximize the quality and comprehensiveness of the care they receive.
16	Assess patient's/client's health status utilizing medical knowledge, medical records, medical instruments, communication skills, consultation with staff, etc. to determine health care needs.
17	Report findings of patient's/client's health status to the appropriate discipline (e.g., physician, nurse practitioner, dietician, dentist) based on patient/client assessment findings.
18	Educate patients/clients about their medical conditions to promote and further their participation in their health care planning, utilizing medical information, communication skills, policies and procedures, etc.
19	Review laboratory results, analyses, x-rays and other diagnostic tests in order to manage, and/or prevent patient's/client's illnesses and injuries and to promote health, utilizing policies, procedures, medical reference materials, medical knowledge, etc.
20	Interpret diagnostic tests for critical values and inform physicians per facility protocol to ensure any significant values are addressed accordingly.
21	Count narcotics and document their inventory by comparing the amount of narcotics present to the amount of narcotics previously documented to ensure all are accounted for.
22	Administer treatments (e.g., medication, dressings, injections, etc.) in order to treat or prevent patient's/client's illnesses and injuries and to promote health, utilizing medications, policies, procedures, medical knowledge.
23	Assess and document any side effects of medications to ensure patients/clients are effectively being treated.
24	Notify the physician of any side effects of medication to ensure patient's/client's safety.
25	Develop and/or modify nursing care plans based on patient's/client's current conditions utilizing staff documentation, patient/client assessments, lab values, and other diagnostic tools as needed.

26	Document findings of daily nursing evaluations regarding various conditions (e.g., acute and/or chronic lung disorders, nutritional and/or fluid imbalances, dysphagia and swallowing disorders, etc.) in interdisciplinary notes and appropriate forms per facility protocol to ensure information is recorded.
27	Document all teachings/trainings on a variety of health related topics (e.g., medications, universal/standard precautions, discharge planning, disease prevention, hand washing) per facility protocol.
28	Assess and document Minimum Data Set (MDS) for patients/clients in conjunction with care team utilizing professional training in accordance with USDVA, Department of Health Services, and Centers for Medicare and Medicaid Services per facility protocol.
29	Collect and document data for patient's/client's assessments to ensure quality of care is received for varying purposes (e.g., Medicaid and Medicare services) utilizing professional training in accordance with Federal guidelines and per facility protocol.
30	Provide weekly or monthly summaries using staff documentation, laboratory results, analyses, x-rays and other diagnostic tests to inform other staff and provide continuity of care.
31	Write interdisciplinary notes/summaries weekly, monthly, and/or as needed reflecting patient/client progress to keep staff informed.
32	Monitor the completion of consents, reports (e.g., laboratory, incident), and charts ensuring they are finished and submitted in a timely manner.
33	Complete written incident report regarding patient/client injury to establish a record of the incident, actions taken and current status of recovery.
34	Transcribe physician's orders per facility policy to maintain accurate documentation of actions taken with regard to patient/client care.
35	Orient and/or monitor orientation of patient/client to physical layout of unit and unit routines and explain role of various staff members to ensure their knowledge of the facility and available resources.
36	Monitor and/or ensure the timely completion of patient/client admission process to ensure continuity of care.
37	Complete a comprehensive nursing admission assessment utilizing the patient's/client's history, physical condition, current medications, immunizations, treatment and responses, and bio/psycho/social condition per facility protocol to evaluate the patient's/client's barriers to discharge and initiate the plan of care.
38	Reconcile the patient's/client's medication and vaccination orders by reviewing their past orders with their current orders to ensure accuracy of current medication and vaccinations.
39	Provide input to Unit Manager on employee clinical performance and other related issues.

40	Communicate with oncoming shift about any change in condition and current status of the patient's/client's health conditions and status using established facility protocol to ensure continuity of care.
41	Attend staff meetings to maintain communication with staff regarding policies, procedures and expectations and to problem solve, collaborate, and exchange information.
42	Communicate with patients/clients regarding physical, emotional and bio/psycho/social needs to identify and address care issues that will facilitate improvement and quality of care.
43	Collaborate with primary care providers, physicians, and other health care providers to ensure appropriateness of health care to patients/clients utilizing professional training and various resources in accordance with the guidelines established by regulatory agencies and others.
44	Consult and coordinate with health care team members to plan, implement and evaluate patient/client care plans.
45	Instruct individuals, families and other groups on topics such as health education, disease prevention, and health improvement options.
46	Provide information and assist individuals (e.g., staff, visitors) within the facility as needed in order to maintain positive relationships with the community in accordance with Health Insurance Portability and Accountability Act (HIPAA) and other appropriate guidelines.
47	Provide in-service training for staff to ensure proficiency and competency of care.
48	Educate patients/clients, peers and others on a variety of health related topics (e.g., medications, universal/standard precautions, discharge planning, disease prevention, hand washing) per facility protocol.
49	Prepare and assist patients/clients with examinations, treatments, and procedures ensuring privacy, confidentiality, comfort and comprehensive understanding in accordance with the guidelines established by regulatory agencies and others.
50	Report any operational conflicts or problems that could potentially delay patient/client services to the appropriate personnel for problem resolution.
51	Provide advice to nursing staff to ensure appropriate care for patients/clients utilizing professional training and skills in accordance with the guidelines established by regulatory agencies and others.
52	Complete mandatory training and obligations as required by facility and regulatory agencies to remain current with professional nursing standards and credentials.
53	Assist patients/clients in daily activities (i.e., bathing, dressing, grooming, dining, etc.), while also lifting and positioning them as needed in accordance with their treatment plans.

54	Notify physician, manager or supervisor on duty immediately when patient/client sustains an injury or change of condition per facility policies and procedures.
55	Perform nursing procedures (e.g., hypodermic injections, urinary catheterization, enemas, etc.) to improve overall health in accordance with the guidelines established by regulatory agencies and others.
56	Provide one-to-one supervision/direct observation of individuals on special precautions (i.e. elopement risk, serious medical condition, suicide risk, etc.) to preserve patient/client safety.
57	Assist the physician with physical examinations (e.g., by preparing the patient's/client's chart, bringing the patient/client to the exam room, taking vital signs, etc.) in order to expedite the physician's evaluations process.
58	Identify and assess changes in patient/client condition that would present health care risks to them to assist in the development and implementation of an appropriate health care plan.
59	Work at different sites within the facility as needed within the scope of practice in accordance with regulatory agencies and established guidelines.
60	Write a discharge summary which includes patient's/client's status and follow-up treatment/care needed for the patient/client and appropriate facilities per protocol.
61	Complete a comprehensive nursing discharge assessment utilizing the patient's/client's history, physical condition, current medications, immunizations, treatment and responses, and bio/psycho/social condition per facility protocol to evaluate the patient's/client's barriers to discharge and summarize the plan of care.
62	Document and follow up on the distribution of discharged patient's/client's property per facility protocol.